House of Representatives

General Assembly

File No. 262

January Session, 2007

Substitute House Bill No. 7263

House of Representatives, April 2, 2007

The Committee on Insurance and Real Estate reported through REP. O'CONNOR of the 35th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING HEALTH CARE CENTERS AND INSOLVENCY PROTECTION.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 38a-193 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

(a) (1) Before issuing any certificate of authority to any health care center on or after July 1, 1990, the commissioner shall require that a health care center have: (A) An initial net worth of one million five hundred thousand dollars, and (B) agree to thereafter maintain the minimum net worth required under subdivision (4) of this subsection.

(2) No health care center shall be licensed to transact business in this state or remain so licensed unless, (A) its net worth bears a reasonable relationship to its liabilities based upon the type, volume and nature of business transacted, and (B) its risk-based capital related to its total adjusted capital is adequate for the type of business transacted. As

used in this subsection, "total adjusted capital" means the sum of a health care center's net worth and any other item in the nature of capital as deemed appropriate by the commissioner; and "risk-based capital" means the net worth of the health care center adjusted to recognize the level of risk inherent in its business, including (i) risk with respect to the health care center's assets, (ii) the risk of adverse underwriting experience with respect to the health care center's liabilities and obligations, (iii) the credit risk with respect to the health care center's business, and (iv) all other business risks and such other relevant risks as the commissioner may determine.

(3) (A) In determining net worth, no debt shall be considered fully subordinated unless the subordination clause is in a form acceptable to the commissioner. Any interest obligation relating to the repayment of any subordinated debt must be similarly subordinated. (B) The interest expenses relating to the repayment of any fully subordinated debt shall not be considered uncovered expenditures. (C) Any debt incurred by a note meeting the requirements of this section, and otherwise acceptable to the commissioner, shall not be considered a liability and shall be recorded as equity.

(4) Except as provided in subdivision (3) and subdivisions (5) to (7), inclusive, of this subsection, each health care center shall maintain a minimum net worth equal to the greater of: (A) One million dollars; or (B) two per cent of its annual premium revenues as reported on the most recent annual financial statement filed with the commissioner on the first one hundred fifty million dollars of premium revenues plus one per cent of annual premium revenues in excess of one hundred fifty million dollars. No health care center authorized by the commissioner to do business in this state, on July 1, 1990, shall be required to comply with the provisions of subparagraph (B) of this subdivision until January 1, 1995.

(5) Each health care center that offers or proposes to offer out-of-network benefits shall either:

(A) Enter into an agreement with a duly licensed insurance

company to provide coverage to subscribers and enrollees outside of the health care center's established network, subject to approval by the commissioner; or

(B) Implement an out-of-network benefit system to be operated by the health care center, subject to approval by the commissioner, provided the health care center establishes and maintains its net worth at an amount equal to the greater of (i) three million dollars, (ii) two per cent of its annual premium revenues as reported on the most recent annual financial statement filed with the commissioner on the first one hundred fifty million dollars of premium revenues plus one per cent of annual premium revenues in excess of one hundred fifty million dollars, or (iii) two months of its cost of uncovered expenditures. For purposes of this subsection, "annual premium revenues" does not include revenue earned as a result of an arrangement between a health care center and the federal Centers for Medicare and Medicaid Services, on a cost or risk basis, for services to a Medicare beneficiary, or revenue earned as a result of an arrangement between a health care center and a Medicaid state agency, for services to a Medicaid beneficiary. For the purposes of this subsection, the uncovered expenditures of the health care center for the requisite two-month period shall be calculated as follows:

$$UE = \frac{(X + Y - Z)}{6}$$

Where:

UE = Uncovered expenditures of the health care center for the requisite two-month period.

X = Total year-to-date uncovered expenditures reported in the health care center's most recent statutory quarterly or annual statement.

Y = Total year-to-date uncovered expenditures reported in the health care center's annual statement for the prior calendar year.

Z = Total year-to-date uncovered expenditures reported in the health care center's statutory quarterly or annual statement for the current calendar quarter of the prior calendar year.

(6) The total cost of the out-of-network benefits of a health care center shall not exceed ten per cent of the total cost of the health care center's claims and expenses on a quarterly basis without the prior approval of the commissioner and the effectuation of an uncovered expenditures insolvency deposit established with the commissioner pursuant to section 2 of this act.

(7) Any health care center that provides out-of-network benefits pursuant to this subsection shall provide a quarterly report concurrent with filing of the required quarterly and annual financial statements which shall demonstrate compliance with the provisions of this subsection.

(8) The commissioner may adopt regulations, in accordance with chapter 54, to implement the purposes of this subsection, including, but not limited to, provisions concerning: (A) The preparation and filing of reports by health care centers relating to risk-based capital levels and the calculation thereof; (B) the preparation and filing of comprehensive financial plans when such capital levels are reduced below minimum threshold levels; (C) the confidentiality of such reports and plans; and (D) the regulatory corrective actions the commissioner may take in the event minimum risk-based capital levels are not maintained, or the health care center's financial plans filed with the commissioner are deficient, or the health care center fails to otherwise comply with the provisions of the regulations.

(b) Every health care center shall, when determining liabilities, include an amount estimated in the aggregate to provide for any unearned premium and for the payment of all claims for health care expenditures which have been incurred, whether reported or

unreported, which are unpaid and for which such organization is or may be liable, and to provide for the expense of adjustment or settlement of such claims. Such liabilities shall be calculated in accordance with those accounting procedures and practices prescribed by the National Association of Insurance Commissioners Accounting Practices and Procedures Manual, version effective January 1, 2001, and subsequent revisions and the National Association of Insurance Commissioners Annual Statement Instructions, subject to any deviations prescribed by the commissioner.

(c) (1) Every contract between a health care center and a participating provider of health care services shall be in writing and shall **[**set forth that in the event the health care center fails to pay for health care services as set forth in the contract, the subscriber or enrollee shall not be liable to the provider for any sums owed by the health care center.**]** contain the following provisions or variations approved by the Commissioner:

"(A) (Name of provider or facility) …. hereby agrees that in no event, including, but not limited to, nonpayment by (name of health care center) …., (name of health care center's) …. insolvency, or breach of this contract shall (name of provider or facility) …. bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against a covered person or person acting on their behalf, other than (name of health care center) …., for services provided pursuant to this contract. This provision shall not prohibit collection of cost-sharing amounts, or costs for noncovered services, which have not otherwise been paid by a primary or secondary carrier in accordance with regulatory standards for coordination of benefits, from covered persons in accordance with the terms of the covered person's health plan.

(B) (Name of provider or facility) …. agrees, in the event of (name of health care center's) …. insolvency, to continue to provide the services promised in this contract to covered persons of (name of health care center) …. for the duration of the period for which premiums on behalf

of the covered person were paid to (name of health care center) …. or until the covered person's discharge from inpatient facilities, whichever time is greater.

(C) Notwithstanding any other provision in this contract, nothing in this contract shall be construed to modify the rights and benefits contained in the covered person's health plan.

(D) (Name of provider or facility) …. may not bill the covered person for covered services, except for cost-sharing amounts, where (name of health care center) …. denies payment because the provider or facility has failed to comply with the terms or conditions of this contract.

(E) (Name of provider or facility) …. further agrees (i) that the provisions of subparagraphs (A), (B), (C) and (D) of this subdivision (or citations appropriate to the contract form) …. shall survive termination of this contract regardless of the cause giving rise to termination and shall be construed to be for the benefit of (name of health care center's) …. covered persons, and (ii) that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between (name of provider or facility) …. and covered persons or persons acting on their behalf.

(F) If (name of provider or facility) …. contracts with other providers or facilities who agree to provide covered services to covered persons of (name of health care center) …. with the expectation of receiving payment directly or indirectly from (name of health care center) …. , such providers or facilities shall agree to abide by the provisions of subparagraphs (A), (B), (C), (D) and (E) of this subsection (or citations appropriate to the contract form) …. ."

(2) In the event that the participating provider contract has not been reduced to writing as required by this subsection or that the contract fails to contain the **[**required prohibition**]** provisions required by subdivision (1) of this subsection, the participating provider shall not collect or attempt to collect from the subscriber or enrollee sums owed

by the health care center.

(3) No participating provider, or agent, trustee or assignee thereof, may: (A) Maintain any action at law against a subscriber or enrollee to collect sums owed by the health care center; or (B) request payment from a subscriber or enrollee for such sums. For purposes of this subdivision "request payment" includes, but is not limited to, submitting a bill for services not actually owed or submitting for such services an invoice or other communication detailing the cost of the services that is not clearly marked with the phrase "THIS IS NOT A BILL". The contract between a health care center and a participating provider shall inform the participating provider that pursuant to section 20-7f, it is an unfair trade practice in violation of chapter 735a for any health care provider to request payment from an enrollee, other than a copayment or deductible, for covered medical services, or to report to a credit reporting agency an enrollee's failure to pay a bill for medical services when a health care center has primary responsibility for payment of such services.

(d) The commissioner shall require that each health care center have a plan for handling insolvency which allows for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to members who are confined to inpatient facilities on the date of insolvency until their discharge or expiration of benefits. In considering such a plan, the commissioner may approve one or more of the following: (1) Insurance to cover the expenses to be paid for continued benefits after an insolvency; (2) provisions in provider contracts that obligate the provider to provide services after the health care center's insolvency for the duration of the period for which premium payment has been made and until the enrollees' discharge from inpatient facilities; (3) insolvency reserves; (4) acceptable letters of credit; or (5) any other arrangements to assure that benefits are continued as specified above.

(e) Every agreement to provide health care services between a provider and a health care center shall require the provider to provide

at least sixty days' advance notice to the health care center to terminate the agreement.

(f) (1) Unless otherwise provided in this subsection, each health care center shall deposit with the commissioner or, at the discretion of the commissioner, with any organization or trustee acceptable to the commissioner through which a custodian or controlled account is utilized, cash, securities or any combination of cash or securities or other measures that are acceptable to the commissioner, which at all times shall have a value of not less than five hundred thousand dollars.

(2) A health care center that is in operation on October 1, 2007, shall make a deposit equal to two hundred fifty thousand dollars. In the second year, the amount of the additional deposit for a health care center that is in operation on October 1, 2007, shall be equal to two hundred fifty thousand dollars, for a total of five hundred thousand dollars.

(3) The deposit shall be an admitted asset of the health care center in the determination of net worth.

(4) All income from deposits shall be an asset of the organization. A health care center that has made a securities deposit may withdraw such deposit or any part thereof after making a substitute deposit of cash, securities or any combination of cash or securities or other measures of equal amount and value. Any securities shall be approved by the commissioner before being deposited.

(5) The deposit shall be used to protect the interests of the health care center's enrollees and to assure continuation of health care services to enrollees of a health care center that is in rehabilitation or conservation. The commissioner may use the deposit for administrative costs directly attributable to a receivership or liquidation. If the health care center is placed in rehabilitation or liquidation, the deposit shall be an asset subject to the provisions of the Insurers Rehabilitation and Liquidation Act.

Sec. 2. (NEW) (*Effective October 1, 2007*) (a) If at any time uncovered expenditures exceed ten per cent of total health care expenditures, a health care center shall place an uncovered expenditures insolvency deposit with the Insurance Commissioner or with an organization or trustee acceptable to the commissioner through which a custodial or controlled account is maintained, cash or securities that are acceptable to the commissioner. The deposit shall at all times have a fair market value in an amount of one hundred twenty per cent of the health care center's outstanding liability for uncovered expenditures for enrollees in this state, including incurred but not reported claims, and shall be calculated as of the first day of the month and maintained for the remainder of the month. If a health care center is not otherwise required to file a quarterly report, it shall file a report not later than forty-five days after the end of the calendar quarter with information sufficient to demonstrate compliance with this section.

(b) The deposit required under this section is in addition to the deposit required under subsection (f) of section 38a-193 of the general statutes, as amended by this act, and is an admitted asset of the health care center in the determination of net worth. All income from deposits or trust accounts shall be assets of the health care center and may be withdrawn from the deposit or account quarterly with the approval of the commissioner.

(c) A health care center that has made a deposit, may withdraw such deposit or any part of such deposit, if (1) a substitute deposit of cash or securities of equal amount and value is made, (2) the fair market value exceeds the amount of the required deposit, or (3) the required deposit under subsection (a) of this section is reduced or eliminated. Deposits, substitutions or withdrawals may be made only with the prior written approval of the commissioner.

(d) The deposit required under this section shall be held in trust separate and apart from all other moneys, funds and accounts and may be used only as provided under this section. The commissioner may use the deposit of an insolvent health care center for

administrative costs associated with administering the deposit and payment of claims of enrollees of this state for uncovered expenditures in this state. Claims for uncovered expenditures shall be paid on a pro rata basis based on assets available to pay the ultimate liability for incurred expenditures. Partial distribution may be made pending final distribution. Any amount of the deposit remaining shall be paid into the liquidation or receivership of the health care center.

(e) The commissioner may, by regulation adopted in accordance with chapter 54 of the general statutes, prescribe the time, manner and form for filing claims under subsection (d) of this section.

(f) The commissioner may, by regulation adopted in accordance with chapter 54 of the general statutes, or by order, require a health care center to file annual, quarterly or more frequent reports deemed necessary to demonstrate compliance with this section. The commissioner may require that the reports include liability for uncovered expenditures as well as an audit opinion.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2007*	38a-193
Sec. 2	*October 1, 2007*	New section

Statement of Legislative Commissioners:
In the second sentence of subsection (f) (2) in section 1, the term "health care center" was substituted for "health maintenance organization" for statutory and internal consistency. In the first sentence of subsection (f) in section 2, the word "by" was inserted before "order" for proper grammar.

INS *Joint Favorable Subst.-LCO*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either chamber thereof for any purpose:

OFA Fiscal Note

State Impact: None

Municipal Impact: None

Explanation

This bill makes several changes to laws affecting private health care centers (i.e., HMOs), and has no fiscal impact.

The Out Years

State Impact: None

Municipal Impact: None

OLR Bill Analysis

sHB 7263

AN ACT CONCERNING HEALTH CARE CENTERS AND INSOLVENCY PROTECTION.

SUMMARY:

This bill makes several changes to laws affecting health care centers (i.e., HMOs). It requires an HMO to deposit $500,000 with the insurance commissioner or designated trustee. The commissioner must use the deposit to provide health care services to the HMO's enrollees if the HMO is placed in receivership (i.e., rehabilitation or conservation) and may use them for related administrative costs.

By law, an HMO may provide out-of-network (OON) benefits to its enrollees, subject to certain financial requirements. Currently, an HMO's OON benefits cannot exceed 10% of its total quarterly health care expenditures (i.e., claims and expenses). The bill instead permits OON benefits to exceed 10% of total expenditures if the HMO first (1) obtains the insurance commissioner's approval and (2) deposits an amount equal to at least 120% of its uncovered expenditures (see BACKGROUND) with the commissioner or designated trustee.

Under current law, an HMO enrollee is not liable for any amount the HMO owes a contracted health care provider for medical services rendered. The bill requires specific contract language holding the enrollee harmless (i.e., not liable). It also requires the contract to inform the provider that it is an unfair trade practice to (1) ask an enrollee for more than his or her copayment or deductible or (2) report an enrollee to a credit agency for not paying a bill for which the HMO is liable.

EFFECTIVE DATE: October 1, 2007

RECEIVERSHIP DEPOSIT

The bill requires each HMO to deposit with the commissioner or, at the commissioner's discretion, with any acceptable organization or trustee through which a custodian or controlled account is used, cash, securities, any combination of these, or other measures acceptable to the commissioner. The deposit must be worth at least $500,000 at all times. An HMO already in operation on October 1, 2007 must deposit $250,000 (presumably in 2007) and in the second year (presumably 2008), it must deposit another $250,000 to meet the $500,000 requirement.

Under the bill, the deposits and all income from them are admitted assets of the HMO when determining the HMO's net worth. An HMO that has made a securities deposit may withdraw all or part of it after making a substitute deposit of equal amount and value. The insurance commissioner must approve any securities before they are deposited.

The bill requires that the deposits be used to protect the interests of the HMO's enrollees and to assure continuation of health care services to them when the HMO is in rehabilitation or conservation. It permits the commissioner to use the deposits for administrative costs directly related to a receivership or liquidation. If the HMO is placed in rehabilitation or liquidation, the deposit is considered an asset subject to the provisions of the Insurers Rehabilitation and Liquidation Act.

UNCOVERED EXPENDITURES DEPOSIT

The bill requires an HMO to place an uncovered expenditures insolvency deposit with the insurance commissioner, or with an acceptable organization or trustee through which a custodial or controlled account is maintained, whenever uncovered expenditures exceed 10% of its total health care expenditures.

The deposit must be in cash or securities acceptable to the commissioner and must at all times have a fair market value equal to 120% of the HMO's uncovered expenditures liability for enrollees in the state, including claims incurred but not yet reported to the HMO.

The HMO must calculate the deposit amount as of a month's first day and maintain that amount for the rest of the month. The bill requires the HMO to file a financial report with the insurance commissioner demonstrating compliance with these requirements within 45 days after the end of a quarter.

Under the bill, the uncovered expenditures insolvency deposit is in addition to the $500,000 receivership deposit. It and all income from it are the HMO's admitted assets when determining net worth, and may be withdrawn quarterly with the commissioner's approval.

The bill permits an HMO to withdraw all or part of the deposit if (1) a substitute deposit of equal amount and value is made, (2) the fair market value exceeds the amount of the required deposit, or (3) the required deposit is reduced or eliminated. Deposits, substitutions, or withdrawals require the commissioner's prior written approval.

The bill requires that the deposit be held in trust separate and apart from all other money, funds, and accounts and may be used only as provided. It permits the commissioner to use the deposit for paying enrollees' claims for uncovered expenditures and related administrative costs. The commissioner must pay claims on a prorated basis based on available assets. Partial distribution may be made pending final distribution. Any amount of the deposit remaining must be paid into the HMO's liquidation or receivership.

The bill permits the commissioner to adopt regulations that set the time, manner, and form for filing uncovered expenditure claims. The commissioner may also adopt regulations or issue an order requiring an HMO to file annual, quarterly, or more frequent reports deemed necessary to demonstrate compliance. The commissioner may require that the reports include liability for uncovered expenditures as well as an audit opinion.

PROVIDER CONTRACT

Hold Harmless Provision

The bill requires a contract between an HMO and a participating

provider to contain the following language or a variation approved by the insurance commissioner:

(A) (Name of provider or facility) …. hereby agrees that in no event, including, but not limited to, nonpayment by (name of health care center) …., (name of health care center's) …. insolvency, or breach of this contract shall (name of provider or facility) …. bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against a covered person or person acting on their behalf, other than (name of health care center) …., for services provided pursuant to this contract. This provision shall not prohibit collection of cost-sharing amounts, or costs for noncovered services, which have not otherwise been paid by a primary or secondary carrier in accordance with regulatory standards for coordination of benefits, from covered persons in accordance with the terms of the covered person's health plan.

(B) (Name of provider or facility) …. agrees, in the event of (name of health care center's) …. insolvency, to continue to provide the services promised in this contract to covered persons of (name of health care center) …. for the duration of the period for which premiums on behalf of the covered person were paid to (name of health care center) …. or until the covered person's discharge from inpatient facilities, whichever time is greater.

(C) Notwithstanding any other provision in this contract, nothing in this contract shall be construed to modify the rights and benefits contained in the covered person's health plan.

(D) (Name of provider or facility) …. may not bill the covered person for covered services, except for cost-sharing amounts, where (name of health care center) …. denies payment because the provider or facility has failed to comply with the terms or conditions of this contract.

(E) (Name of provider or facility) …. further agrees (i) that the provisions of subparagraphs (A), (B), (C) and (D) of this subdivision

(or citations appropriate to the contract form) …. shall survive termination of this contract regardless of the cause giving rise to termination and shall be construed to be for the benefit of (name of health care center's) …. covered persons, and (ii) that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between (name of provider or facility) …. and covered persons or persons acting on their behalf.

(F) If (name of provider or facility) …. contracts with other providers or facilities who agree to provide covered services to covered persons of (name of health care center) …. with the expectation of receiving payment directly or indirectly from (name of health care center) …. , such providers or facilities shall agree to abide by the provisions of subparagraphs (A), (B), (C), (D) and (E) of this subsection (or citations appropriate to the contract form) …. .

BACKGROUND

Uncovered Expenditures

Uncovered expenditures are costs for health care services that the HMO is obligated to pay for which an enrollee may be liable if the HMO is insolvent. Uncovered expenditures do not include (1) expenses for which a provider has agreed not to bill the enrollee even if the HMO does not pay the provider or (2) services that are guaranteed, insured, or assumed by another person or organization other than the HMO.

Insurers Rehabilitation and Liquidation Act

The Insurers Rehabilitation and Liquidation Act gives the insurance commissioner broad authority to supervise, rehabilitate, or liquidate a financially impaired or insolvent HMO to protect the interests of enrollees, claimants, creditors, and the general public. Among other actions, the commissioner can void fraudulent transfers, preferences, and liens; seek recovery of premiums; dispute claims; prohibit certain financial transactions; and distribute an insolvent HMO's remaining assets to enrollees and other claimants.

Unfair Trade Practice

The Connecticut Unfair Trade Practices Act (CUTPA) prohibits businesses from engaging in unfair and deceptive acts or practices. It allows the Department of Consumer Protection commissioner to issue regulations defining what constitutes an unfair trade practice, investigate complaints, issue cease and desist orders, order restitution in cases involving less than $5,000, enter into consent agreements, ask the attorney general to seek injunctive relief, and accept voluntary statements of compliance. It also allows individuals to sue. Courts may issue restraining orders; award actual and punitive damages, costs, and reasonable attorneys fees; and impose civil penalties of up to $5,000 for willful violations and $25,000 for violation of a restraining order.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable
Yea 19 Nay 0 (03/13/2007)